

## **Piloting Payment by Results for Drugs Recovery**

# **Invitation to Participate**

## **Payment by Results Pilots: Invitation to Participate**

One of the major aims of the new Drugs Strategy 2010 *Reducing Demand, Restricting Supply, Building Recovery* is to put the goal of recovery for those who are dependent on drugs or alcohol at the heart of all activity. As part of this commitment to recovery, a key action from the Drug Strategy is the development of pilots to test new approaches to the commissioning and delivery of drugs recovery systems that reward achievement of outcomes.

Proposals are invited from local areas for potential pilots to implement a Payment by Results (PbR) approach to recovery for individuals who are drug dependent, henceforth referred to as the Drugs Recovery PbR. The aim is to incentivise and reward providers that support individuals, including those in contact with the Criminal Justice System (CJS), to recover from their drug dependence, resulting in clear outcomes for the individual, their families and communities. Multi-partnership submissions (covering more than one local authority area) are welcomed.

The models developed for the Drugs Recovery PbR will cover all treatment and recovery services for adults (18 years and over) in the locality. Successful partnerships will be expected to test out new and innovative commissioning and delivery models, including developing their own approaches to payment by results, to deliver improved outcomes. **Please note that there is no additional funding being offered for these pilot schemes: local areas will be expected to re-organise current treatment delivery systems into PbR models within their existing available budgets.**

While we would expect pilot schemes to work closely with the DWP Payment by Results Work Programme, we are keen to be able to evaluate the impact of the Drugs Recovery PbR pilots in their own right. Our preference would therefore be for pilot areas to be those that are not involved in piloting (or planning to pilot) other PbR models (e.g. the Ministry of Justice PbR approaches). However, we recognise that this may not always be possible.

This work programme is overseen and commissioned jointly by a cross-government

Steering Group led by the Department of Health, and including representation from the Home Office, the Ministry of Justice, the Department for Work and Pensions, the Department for Communities and Local Government, Cabinet Office, and the National Treatment Agency for Substance Misuse.

This is an important - and challenging - programme of work, and the outcomes from the pilots will help to determine the future direction of drug recovery funding, commissioning and delivery systems.

The pilots will commence with a co-design period in April 2011 and will aim to go live from September 2011, running for a minimum of two years. It is appreciated that it will be challenging to deliver the full spectrum of potential change in the early stages of the pilots, particularly as it may be necessary to work within existing contractual commitments, and given the wider reforms that are also taking place. It will be critical to success to ensure that local service providers are fully involved in planning from the inception of the pilots. Proposals should describe how implementation could be phased to achieve increasing, sustainable benefits over the life of the pilot and beyond.

The Invitation to Participate will be of particular interest to those partnerships that have a substantial 'track record' in managing the pooling of budgets, developing effective lead commissioning arrangements with a range of partners at local level, and have the skills and commitment to be able to lead the shift in commissioning and delivery, encouraging a step change in performance alongside the stimulation of innovative ideas.

The selection of partnerships to develop and implement pilots is through a two-stage process. The initial stage is the submission of Pre-qualification questionnaires (PQQs). A cross government selection panel, appointed by the National Steering Group, will evaluate these PQQs and select those partnerships who will be invited to expand their PQQs into full proposals. Deciding factors will include the need to have a good geographical spread of pilots as well as a blend of unitary and two tier authorities and different proposed models.

**The closing date for pre-qualification questionnaires is 12.00 midday on Thursday 20th January 2011.**

Potential applicants who wish to discuss this programme of work are invited to contact:

Megan Jones at [Megan.Jones@nta-nhs.org.uk](mailto:Megan.Jones@nta-nhs.org.uk) or on 020 7972 1975

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## **Payment by Results for Recovery Pilots: Specification**

### **1. Introduction**

Significant investment has been made in the drug treatment system over the last decade. There are now far more people in treatment than ten years ago, waiting times have fallen sharply and there is a range of good practice in multi-agency working. Existing drug funding, commissioning and delivery systems have helped to deliver an unprecedented increase in drug treatment, supporting individuals on their recovery journey. We want to create a recovery system that focuses not just on getting individuals into treatment and process driven targets, but on the achievement of sustained recovery. We believe incentivising services through a Payment by Results approach can help support this ambition.

This pilot programme will work with local areas to simplify funding, commissioning and delivery of drug recovery services by pooling available drug-related funding, and aligning duplicating systems, particularly around assessment and referral. This will enable more funds to be freed up to commission improved recovery outcomes, and will support individuals through a more joined-up approach. While the pilot programme has been designed primarily to focus on meeting the recovery needs of drug dependent adults in the community, we would be pleased to hear from local partnerships who wish to propose integrated pilot projects to address a wider range of needs, for example those of offenders coming off long sentences and/or people dependent on alcohol.

PbR for Drugs Recovery pilots will aim to provide a transparent funding system for drug recovery services based on the achievement of high level and interim outcomes. The pilots will be closely supported by the new Public Health England, where the core project team will be based from April 2012.

Local areas interested in wishing to participate in the pilot programme will need to be able to demonstrate fully joined-up partnerships, with evidence of strong joint commissioning arrangements across the broad range of relevant partners and their budgets (PTB, DIP, Local Authority Community Care budget, mainstream PCT,

etc.), based on mature and constructive relationships between local commissioners and providers. Areas will also need to demonstrate confidence that there is both appetite and capability within their potential market of service providers, such that they are ready to respond to the challenges presented by the PbR pilot programme.

## **2. Programme**

An overview of how the pilots will operate has been developed by central government to set the direction of travel. However, there is much more work to do to develop the detail, including on the outcome measures, and we will want to work with the successful pilot sites to co-design the details to give the pilots the best chance of success.

Please note that throughout this document “PbR for Drugs Recovery” is used to describe the whole recovery system, which is envisaged as including both directly commissioned components as well as PbR recovery providers (see Annex A for some possible PbR models).

The proposal for a PbR for Drugs Recovery approach to incentivise providers is based upon the following principles:

- National Government sets the overall framework of outcomes and tariffs;
- Local areas would be able to ‘top-up’ tariffs;
- Providers develop the solutions and activities to achieve the outcomes, with evidence about ‘what works’ collated by national government;
- Negotiations will be needed to determine the appropriate sharing of risk between State and provider;
- Individuals should be supported and involved in their choice of provision
- Budgets and responsibility should be devolved where possible;
- Funding streams should be pooled and outcome based; and
- Market disciplines and competition should be encouraged.

It is envisaged that a more transparent funding system for recovery outcomes would facilitate:

- More productive and outcome focussed discussions between commissioners and providers
- The development of best practice service models in terms of clinical and cost effectiveness.
- Bench-marking for providers and commissioners
- Greater investment in proven interventions
- Better care leading to better outcomes for service users.
- Innovation
- New entrants to the market

Payment of the tariff will be subject to achieving the high level outcomes that have been agreed by Ministers which are:

- Individuals following their planned discharge from the system free from drug(s) of dependence do not re-present to drug treatment for 12 months.
- Reduced recidivism, or continued non-offending for those not in contact with the Criminal Justice System prior to scheme enrolment.
- Employment
- Health and well-being

The technical detail behind the metrics for these high level outcomes will be further developed as part of the co-design phase of the project. The high level outcomes and detailed metrics will be tested as part of the piloting process.

We envisage that part payment of the tariff will be payable on achievement of interim outcomes, the weighting of which will be determined as part of the project development.

### **3. Piloting through co-design**

The principle of piloting through co-design is critical to the success of the pilots. While this invitation lays out the broad principles we are seeking to deliver through the pilots, we do not want to prescribe the contracting approach to be taken in each

pilot area. We are particularly keen to see a range of models piloted including, but not limited to, exploring the viability of a framework contract model that would allow a range of providers to compete, and a 'prime provider' contract (see Annex A for more information). We are also very keen to see some of the pilot areas examine the possibility of using social finance models to fund service delivery, thereby enabling smaller providers to compete.

Local areas wishing to participate in the pilot programme will in the first instance be required to return a PQQ. Following this, a shortlist of approximately 15 areas will be asked to submit a full proposal by the 20 February, outlining why they are suitable to be considered and what innovative approaches they might take to delivery, as well as their capacity to deliver the change. The Project Manager/Team will then work together with around six successful areas to co-design pilots, ensuring that there is an appropriate balance between national requirements and the flexibility required by local circumstances.

The development of tariffs will be another important component of the co-design process. This work will be supported and assured by an Expert Group (see 'Project Governance' below), in conjunction with the pilot areas. The Expert Group will work with the pilot areas through the Project Manager/Team to consider questions such as: whether tariffs could be supplemented by local funding; the measurement of key outcomes; and the weighting of interim versus final outcome payment, without closing the door on different approaches if the co-design process throws up workable alternatives.

This co-design process is seen as key to successful delivery of workable PbR pilots, and is intended to ensure that we have appropriate buy-in from local areas, providers, service users and other key local partners. Above all, we want to maximise the opportunity to draw on local and specialist expertise in developing pilots that are tailored to the needs of each locality.

#### 4. Description of the proposed model

The Drugs Recovery PbR pilot potentially means significant change to the current commissioning/provider landscape for local partnerships. We will work with successful pilot areas to develop the detail of the model for each area.

Potential PbR schemes may be delivered either by a single prime provider, by multiple providers within a recovery provider framework (with criteria for inclusion being set by partnerships), or by alternative models proposed and tested by pilot sites. Recovery providers could subcontract parts of their service as necessary to achieve outcomes, which would in turn trigger payments. The level of payment for achievement of outcomes (tariff) will vary dependent on the presenting needs of individuals accessing the Drugs Recovery PbR scheme.

Whilst the pilots will be locally driven, we are keen to ensure some consistency in terms of providing support to individuals as they move through their recovery journey. Therefore, building on existing local drugs intervention systems, we will require all local areas involved in the pilots to provide a **Local Area Single Assessment and Referral System (LASARS)** to complement and support drug users into recovery<sup>1</sup>. This service will provide initial triage and assessment for all drug users identified through: self-referral in the community, through Criminal Justice referrals in police custody, at court, through probation services and in prison. Local areas not involved in the pilots will also be encouraged to consider the best practice learning from the pilots and move towards setting up similar LASARS. Whilst the LASARS service may differ in detail across areas, common standards are likely to include:

1. Assessing and identifying individual needs and ensuring any immediate treatment requirements are met
2. Tariff – Setting the appropriate PbR tariff for the individual following assessment
3. Referral – Referring the individual to the most suitable PbR provider to meet their needs.

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<sup>1</sup> This provides a single service to replace and join up existing separate assessment provision.

4. Advocacy – where necessary acting as a contact point for individuals engaged in drug recovery PbR schemes, expressing their views or acting on their behalf to help them secure the most appropriate PbR services
5. Data – testing/managing information systems capable of recording outcomes and payments relating to the individuals engagement with the PbR scheme
6. Responsibility for ensuring immediate treatment requirements are met (e.g. detoxification, harm minimisation);
7. Responsibility for immediate Criminal Justice requirements (e.g. court reports for Restriction on Bail conditions, determining Conditional Caution conditions, carrying out Required Assessments under Drugs Act provisions etc.); and
8. Proactive engagement and encouragement for those individuals who do not wish to engage with a recovery provider at this stage (particularly where their addiction has led to offending).

Any potential conflict of interest between the LASARS and Drug Recovery PbR providers will need to be carefully managed at local level.

Entry onto the Drug Recovery PbR programme should be contingent upon assessment of clinical need. We believe the aim of the LASARS should be to pass individuals to a PbR provider at the earliest opportunity. Timescales for assessment and subsequent referral and engagement in recovery services need to be as short as reasonably possible, and contractually agreed to ensure the referral service does not become a drugs recovery provider. Such an assessment and referral service will need to be underpinned by a comprehensive local joint strategic needs assessment. The identified Drugs Recovery PbR provider will be responsible for delivering all of the outcomes specified, either through direct provision and/or through sub-contracting arrangements with other providers. At the heart of this model is the principle of providers being given the freedom to determine the most effective way of achieving the outcomes.

However, we recognise that this is very much a model that has been developed from the centre and we will want to work with the pilots to ensure that the focus is on what works on the ground.

Illustrations and examples of the journeys individuals may take through the potential system are provided at Annex A.

## **5. Outcomes sought**

We are keen to achieve the right balance between ensuring that there is consistency of ambition between the different pilot areas and allowing room for genuine, locally driven innovation. We will therefore set the high level outcomes nationally, but work with local areas as part of the co-design process to ensure there is flexibility to reflect local circumstances. The current outcomes being considered for the drugs recovery PbR pilot programme are as follows:

### **Free from drug(s) of dependence**

#### ***Interim Outcome***

Defined as an individual having a planned exit from the treatment component of their recovery journey.

In order for the discharge to be planned, the clinicians involved will need to be satisfied that an individual has overcome their dependence and they are no longer using any drugs in a problematic/ addictive fashion, nor are they using other substances (e.g. alcohol) in a way that is likely to trigger a relapse into dependency at a later date. Leaving treatment free of drug(s) of dependence is an established measure, data for which is collected by the National Drug Treatment Monitoring System (NDTMS). The submission of Treatment Outcome Profile data which records drug use in the 28 days prior to discharge enables audit of the outcome as reported. The Local Assessment and Referral System could collect the data at an annual review and at the point of discharge, thereby providing independently verifiable data.

#### ***Final Outcome***

The individual following their planned discharge from the system (as defined above) does not re-present to drug services for 12 months.

In advance of the delivery phase of the pilots, from September 2011, a number of additional methods of verifying sustained freedom from drug dependence will be developed. They could include:

- Individuals tracked over time to ensure that they do not turn up in other parts of the system that would suggest failure (e.g. in the police station on a drug related charge and assessed as having an active drug problem).
- If an individual re-presents in any way, they would need to go through the Local Assessment and Referral System. Therefore there could be independent verification of whether a person has been discharged inside the last 12 months.

### **Offending**

The overall offending outcome would be the reduced recidivism of individuals within the Programme, or continued non-offending for those who have not previously offended. This outcome is still being developed: its further development, including how it can best be measured, is an early task of the expert group.

### **Employment**

The overall employment outcome will be sustained employment or full-time education, and will be measured using rate of people moving off benefit as a proxy. DWP are giving consideration to funding the achievement of the employment outcome in the same manner it is proposing to fund outcome payments in the Work Programme.

### **Health and Well-being**

An interim health and wellbeing outcome is being developed.

This combination of interim and final outcomes should enable pilot areas to strike the correct balance between payments to PbR schemes for delivery of outcomes for individuals, while ensuring schemes are adequately resourced to respond to the immediate needs of individuals.

## **6. Funding**

During co-design, pilot sites will need to determine whether and how to fund this new provision alongside any existing service provision, in areas which may already be contracted. Overlapping provision may need to be funded in certain areas for some period. It is highly likely that flexibilities will have to be negotiated with established local providers to enable the PbR pilot scheme to start.

## **7. Project governance**

Centrally, the project will be led by the Department of Health who are chairing the cross government National Steering Group to take decisions and be held accountable. This will be supported by a National Expert Group that will inform the more detailed work of the Project Team, who will be responsible for the day-to-day development and delivery of the pilots. We would look for the pilot sites to have representation on the Expert Group.

Governance for each pilot will be for each local area to decide. However, it is likely to be helpful to have a project manager in place to have a clear point of accountability and a clear driver for this work. The project manager (or lead contact) for each pilot area will have the opportunity to work closely with the National Project Manager/Team, National Expert Group and other pilot sites as part of the co-design process.

The co-design process will identify the most appropriate means of reporting progress and sharing best practice across all pilot sites. The aim of the project is not to impose additional reporting burdens on pilot areas, but to enable measurement of outcomes from existing national datasets, to facilitate constructive dialogue across pilot sites, and to collate and share best practice nationally.

## 8. Timeline

Date	Milestone
Dec 2011	Invitation to participate in pilot programme sent out
Jan 2011	PQQs returned by 20 Jan 2011. Up to 15 partnerships invited to submit full proposals
Feb 2011	Stakeholder workshop
Mar 2011	Pilot sites selected and signed off by Steering Group
April– Sept 2011	Co-design. Project team and pilot sites work closely to develop the detail of each pilot. Evaluators appointed.
Oct 2011	Pilots Start
Oct 2012	Modification of tariffs in line with learning from pilot sites
Oct 2013	Final assessment and evaluation of pilots
2014/15	Consideration of national roll-out

## 9. Brief for Pilot Proposals

Partnerships are invited to submit pre-qualification questionnaires (PQQs) in the first instance, using the pro forma attached in Annex B.

The PQQ process is being used to ask some basic questions, and identify the suitability of local authority areas to pilot the Drug Recovery PbR programme.

We are looking for around six pilot sites who will deliver a range of PbR models.

Once the PQQs have been assessed, a number of local authority areas (up to 15) will be invited to develop full proposals. It is anticipated that those areas chosen to develop a full proposal will be notified during the week beginning 31st January 2011.

## 10. Criteria for developing and selecting proposals

There are a number of criteria, against which local authority areas submitting PQQs and subsequent full proposals will be judged:

- Ability to demonstrate understanding/experience of outcome-focussed delivery and commissioning for outcomes, including demonstrable positive outcomes.
- Evidence of strong joint commissioning arrangements across the broad range of relevant partners and mature and constructive relationships between local commissioners and providers
- Evidence of robust local finance, data collection and monitoring systems, and good use of local outcome information for commissioned services
- Evidence of delivery of person-centred and recovery-focused systems and services which extend beyond clinical treatment to include reintegration services, access to meaningful activities and family support services
- Evidence of development of successful peer support/advocacy services
- Evidence of robust local needs assessment and innovative responses to local needs
- Robust performance monitoring and performance improvement arrangements are in place.
- Strong strategic links between treatment, reintegration and offender services
- Evidence of ability to identify key risks and propose contingencies to address them
- Demonstration of recovery systems which can rapidly develop the core delivery vehicle described above (LASARs)
- Demonstration of a potential market of service providers that is ready to respond to the challenges presented by the PbR pilot programme

Partnerships who are asked to provide a full proposal at the second stage should be prepared to provide more detailed information on:

- Proposed funding arrangements
- Proposed arrangements for transition from existing commissioning system to the new PbR model

- Costs associated with any changes to existing contracts and/or staffing arrangements. It will be for partnerships to obtain definitive advice on TUPE, matched specifically to the nature of the proposal, if applicable.
- What improved outcomes (in addition to the national outcomes described above) the proposal will deliver and how these will be measured by the partnership.
- Proposed arrangements for sharing of risk between commissioner and local provider(s)

A cross-government panel made up of the Government Departments on the Drug Recovery PbR Pilot Steering Group will review all PQQs. The panel will consider the proposed pilot, the track record of the key partners within the local area and the above criteria. As part of the evaluation of the PQQ's, the panel may also seek the views of NTA Regional Managers. The panel may also refer to the National Expert Group, an advisory committee made up of other key stakeholders such as independent academic experts, recovery provider umbrella bodies, service users and carers. In selecting the pilot sites, the panel will where possible ensure a broad geographical spread of pilots, a blend of two-tier and unitary local authority areas and different proposed models.

This document is purely an invitation to submit a PQQ that may or may not result in a partnership receiving an invitation to submit a full proposal. If PQQs are not successful, the PbR Steering Group will not issue invitations to proceed to full proposal. The decision of the panel will in all cases be final.

## **11. Evaluation**

An evaluation process for the pilots will be developed during the co-design process. Each pilot partnership must engage with the performance evaluation process as a condition of selection. The quantitative evaluation will specify the fixed and comparable data which partnerships will need to gather to ensure that there is a consistency of approach. This will be based on existing data sources and no

additional burdens will be placed on partnerships to gather new sources of information and data in pursuit of the aims of the evaluation.

## **12. Accountability and Performance Management**

In order to manage pilots, track drug users' progress and report performance, partnerships will need to ensure they have robust monitoring performance and financial management systems in place to track progress and oversee processes.

## **13. Summary of Responsibilities of Successful Pilot Sites**

Over and above fulfilling existing responsibilities for delivering services to target and within budget, pilot sites will be expected to:

- develop and implement pilots as per proposals;
- contribute to central and local evaluation;
- hold regular progress reviews; and
- participate in the programme knowledge network and other mechanisms for dissemination of best practice.

## **14. Who can apply**

The invitation to participate is not confined to existing drug partnerships. Any regional or local authority based partnerships or consortia who wish to submit a proposal are invited to do so.

Any such partnerships would need to be both legally and functionally capable of coordinating the relevant budgets and commissioning the services required. Proposals will only be considered if they can demonstrate a partnership or consortium arrangement that includes partners who can comply with the above. This applies to third sector, private and statutory sector applications.

While we are keen to evaluate the impact of the Drugs Recovery PbR pilots in their own right, we would expect them to work closely with the DWP's PbR Work Programme. Our preference would be for pilot areas not to be involved in piloting other PbR models (e.g. the Ministry of Justice PbR approaches). However, we recognise that this may not always be possible, and will consider the advantages and disadvantages of multiple pilots as they are described in each proposal.

## **15. Submitting pre-qualification questionnaires (PQQs)**

PQQs should arrive no later than 12.00 midday on Thursday 20th January 2011, using the pro forma attached in Annex B. PQQs received after this time and date, or not on the attached pro forma, will not be considered. It is the responsibility of the sender to ensure that the proposal has arrived by the deadline stated. An electronic copy of the proposal should be received by this deadline. This is an electronic-only submission process. PQQs must be completed on the attached pro forma and must include the name and full contact details of the person to whom queries may be directed.

PQQs should be emailed to Megan Jones ([Megan.Jones@nta-nhs.org.uk](mailto:Megan.Jones@nta-nhs.org.uk)).

## **16. Further Information**

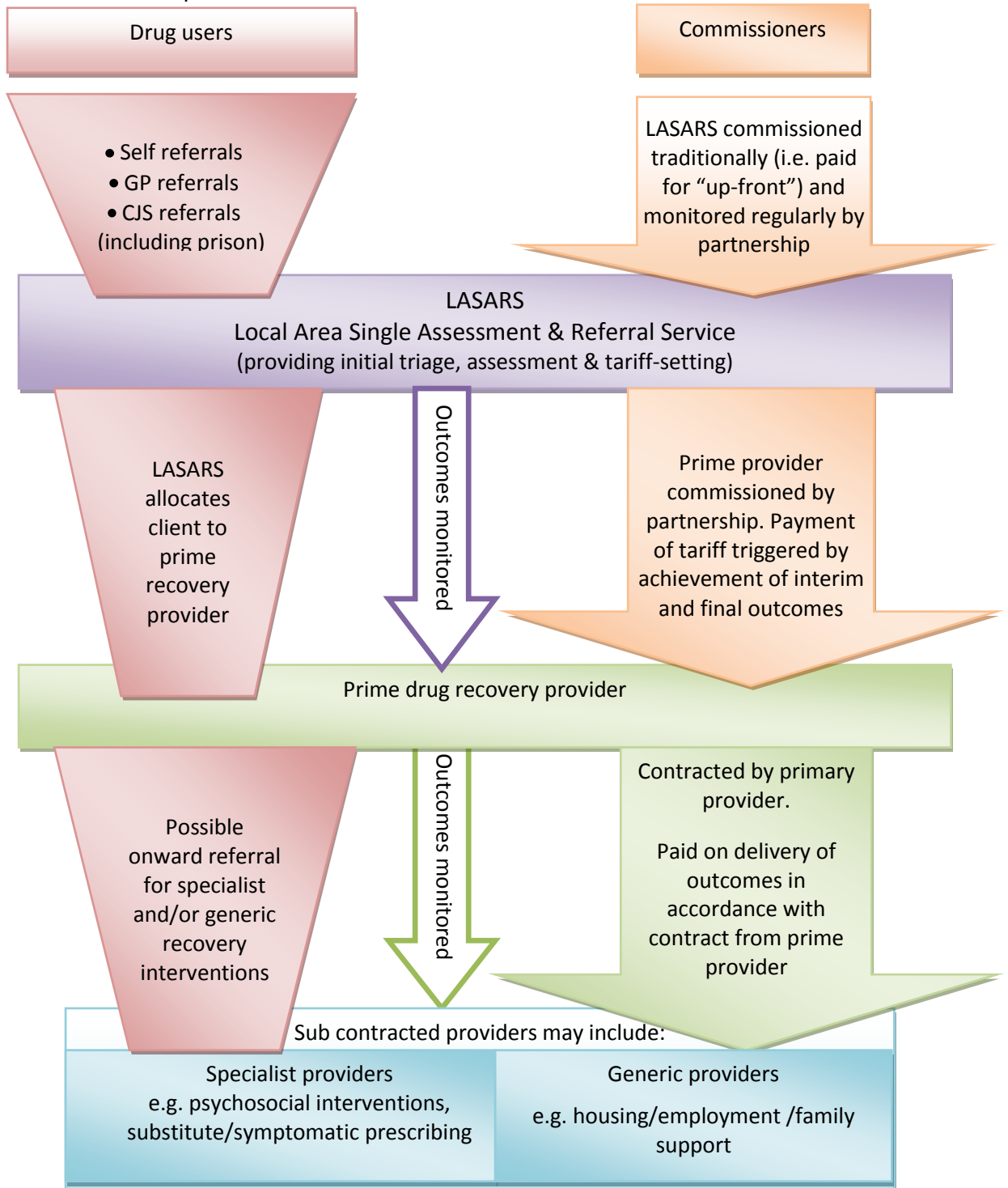
Further information is available from Megan Jones at [Megan.Jones@nta-nhs.org.uk](mailto:Megan.Jones@nta-nhs.org.uk) or on 0207 972 1975. If they wish to do so, potential applicants are invited to contact her to clarify any issues they may have. The alternative contact is Emma Christie, Programme Manager, National Treatment Agency at [Emma.Christie@nta-nhs.org.uk](mailto:Emma.Christie@nta-nhs.org.uk) or on 0207 972 1942.

# ANNEX A

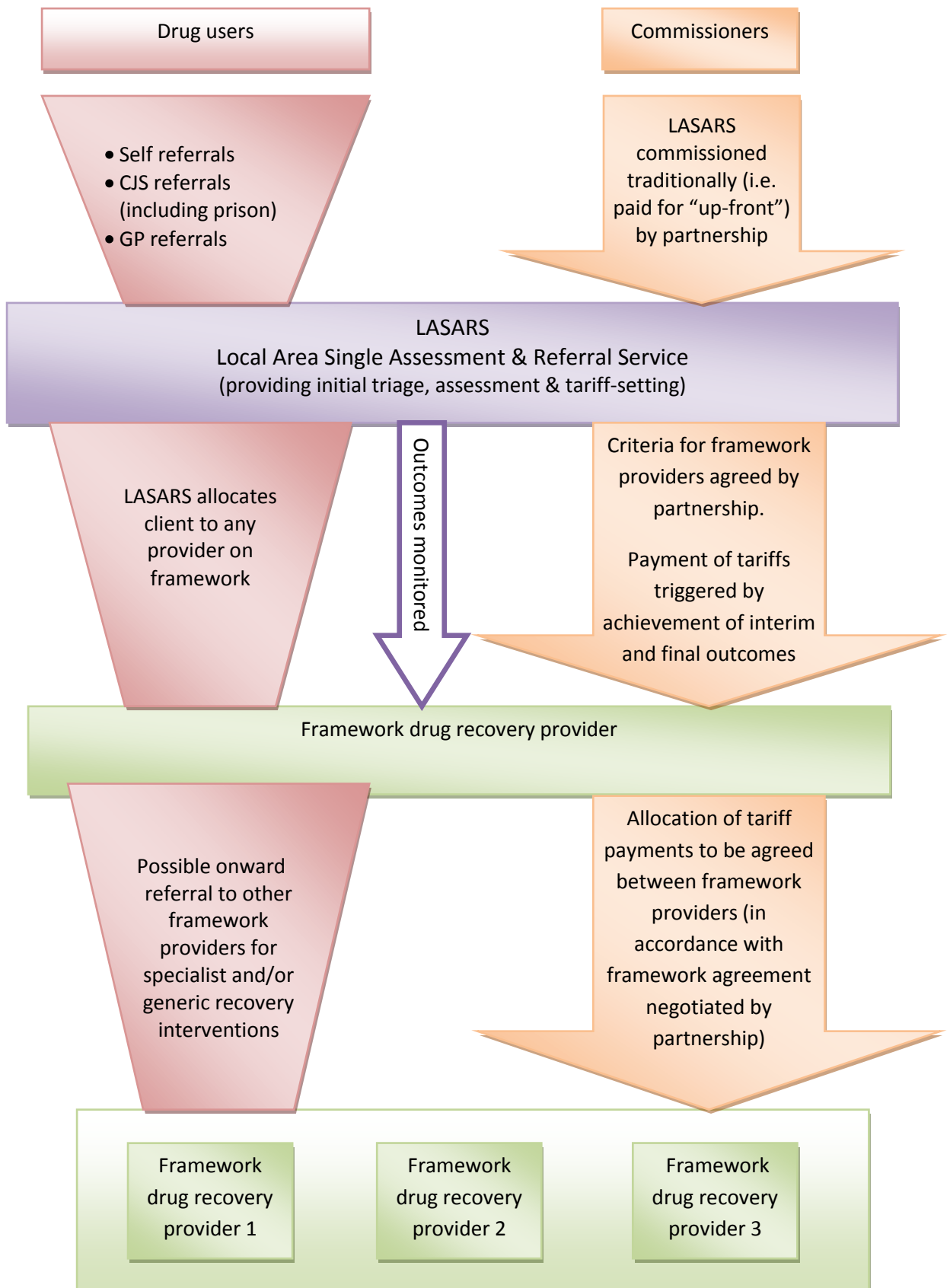
## Possible PbR Models

The diagrams below show how individuals will pass through the Local Area Single Assessment and Referral System (LASARS) to the appropriate PbR recovery provider, detailing how the commissioning of the PbR recovery pathway differs from traditional commissioning models in the two possible examples chosen.

Model 1: PbR Prime provider



## Model 2: PbR Framework



All individuals with a drug dependency will enter a Drugs Recovery PbR via the LASARS. Access to the LASARS might be from a number of different routes but the LASARS will always be the only point of access to drug recovery services in the PbR pilot area. Under the new PbR approach LASARS will be commissioned by the partnership. The partnership will also commission the prime provider or agree the criteria for providers within the framework arrangement as applicable.

### **Example 1 – Community Self-referral**

For a client who self-refers in the community the process would be that wherever they refer (e.g. GP) the individual would be referred to the LASAR System.

Once the individual attends the LASARS, they would be assessed for their immediate needs and their current inclusion on any PbR scheme would be established. The LASARS would work with the individual to determine their needs and a tariff would be allocated for their recovery<sup>2</sup>. They would be assisted to explore the recovery options and choose a suitable provider within the Drugs Recovery PbR. At this point the LASAR system would make arrangements with the chosen recovery provider to take on the client and would take appropriate steps to facilitate the client successfully starting with the recovery provider. Drugs recovery providers in the pilot areas will be required to take all referrals to their service, and cannot refuse to work with individuals based on allocated tariffs or perceived financial risk.

The Drugs Recovery provider would determine the care plan with the individual and take over working with them.

At agreed intervals the LASARS will monitor the outcomes of the Drugs Recovery PbR for the individual and trigger payments<sup>3</sup>. If the individual's circumstances change so that the current provider is no longer appropriate (e.g. moving local area, going to prison, determining that interventions no longer appropriate) the LASARS

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<sup>2</sup> Establishing an individual's need is an often complex process that requires more than one meeting. There may be occasions where the provider could be identified before a final tariff can be set and adjustments may need to be made. The pilots will establish how to manage this process.

<sup>3</sup> Subject to agreement during the co-design process, the LASARS may also make adjustments to tariffs at review stages.

will have responsibility for providing advocacy support and brokering the transfer to another area (through their LASARS) or to an alternative provider in the same area.

### **Example 2 – Referral through Court – Drug Test in police custody**

For a client that is identified in police custody through a drug test the LASARS will provide the Initial Assessment under the Drugs Act 2005 (normally in police custody). The client would be assessed for their immediate needs and their current inclusion on any PbR scheme would be established.

If the client is willing the LASARS would work with the individual to determine their ongoing needs and a tariff would be allocated for their recovery<sup>4</sup>. They would be assisted to explore the recovery options and choose a suitable provider within the Drugs Recovery PbR.

Local areas would need to determine whether the Follow-Up Assessment under the Drugs Act 2005 would be provided by the LASARS or the PbR provider where a client is accepting their need for recovery support. The LASARS would also provide court reports for Restriction on Bail conditions where the individual has not yet been referred to a recovery provider. Recovery providers working with offenders will need to agree to provide all necessary legal provisions to work with this group.

At this point the LASAR system would make arrangements with the chosen recovery provider to take on the client and would take appropriate steps to facilitate the client successfully starting with the recovery provider.

The Drugs Recovery provider would determine the care plan with the individual and take over working with them.

At agreed intervals the LASARS will monitor the outcomes of the Drugs Recovery PbR for the individual and make payments. If the individual's circumstances change

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<sup>4</sup> Establishing an individual's need is an often complex process that requires more than one meeting. There may be occasions where the provider could be identified before a final tariff can be set and adjustments may need to be made. The pilots will establish how to manage this process.

so that the current provider is no longer appropriate (e.g. moving local area, going to prison, determining that interventions no longer appropriate) the LASARS will have responsibility for providing advocacy support and brokering the transfer to another area (through their LASARS) or to an alternative provider in the same area.

### **Example 3 – Referral through Prison**

For an offender identified in prison the LASARS will provide an assessment of their needs and refer them to the prison drug recovery provider (where this is necessary).

If the offender is willing the LASARS for the area in which the prison is located would work with the individual to determine their ongoing needs. The local LASARS would liaise with the LASARS in the area where the person lives, if these are different, to allocate a tariff for their recovery on release from prison and agree an approach to managing the individual.

The LASARS would work with the offender to explore the recovery options on release and choose a suitable provider (where this is relevant). They will also agree with the 'home' LASARS how the release from prison will be managed (this may be by the Drugs Recovery PbR provider).

At this point the LASAR system would make arrangements with the chosen recovery provider to take on the offender and would take appropriate steps to facilitate the individual successfully starting with the recovery provider (this may include the provider starting to work with the client before they leave custody).

In the case of Drugs Recovery providers taking the case they would determine the care plan with the individual and take over working with them.

At agreed intervals the LASARS will monitor the outcomes of the Drugs Recovery PbR for the individual and make payments. If the offender's circumstances change so that the current provider is no longer appropriate (e.g. moving local area, going to prison, determining that interventions no longer appropriate) the LASARS will have responsibility for providing advocacy support and brokering the transfer to another area (through their LASARS) or to an alternative provider in the same area.

**Drugs Recovery PbR  
Pre-qualification Questionnaire**

1) Please briefly summarise (in 250 words or less) why you would like to become a Drug Recovery PbR pilot area

2) Which model would you be primarily interested in providing

Prime Provider

Framework

Other

If "Other" please briefly summarise your preferred model (no more than 100 words)

3) Are all relevant local partnership stakeholders on board with this proposal?

PCT Yes  No  Not yet consulted/decided

Police Yes  No  Not yet consulted/decided

Prison Yes  No  Not yet consulted/decided

Probation Service Yes  No  Not yet consulted/decided

Local Authority Yes  No  Not yet consulted/decided

Service user reps Yes  No  Not yet consulted/decided

Please summarise below your plans for consulting/bringing on board partners who have not yet been consulted or remain undecided

4) Which of the following budgets are you proposing to bring into the PbR pilot?

Pooled Treatment Budget	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
IDTS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not applicable <input type="checkbox"/>
CARATS funding	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not applicable <input type="checkbox"/>
DIP Main Grant	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
DIP Police allocation	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not applicable <input type="checkbox"/>
PCT mainstream budget	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Local Authority Community Care budget	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Other budget(s)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

If Yes, please specify

5) Do you have the local contractual flexibility with currently commissioned providers to start a PbR pilot in October 2011?

Yes

No

If No, please briefly summarise when you would expect to be able to start

6) Are there any other factors or issues you would like to bring to our attention? (again, please limit to 250 words)

Proposals will be assessed against the above criteria. In addition, the following factors will be taken into account: history of local TOP compliance, level of successful treatment completions and re-presentation rates to treatment/DIP (one year post discharge). The scores will inform the panel's decision, which will be final.

**Contact details for communications**

Name

Position

Organization

Phone no.

Email address